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ABSTRACT

Homeless people with alcohol and other drug problems present the traditional substance abuse services delivery provider with special challenges. This paper discusses the optimal designs of comprehensive treatment services for homeless persons with alcohol and other drug problems. Most importantly, the homeless must have immediate access to a safe setting where they may at least temporarily reside. Providers must then place the client in the appropriate level of care in the continuum of services. Likewise, through intensive case management or other service, the provider must address the multiple needs of the homeless, including health and dental care, mental health treatment, vocational training, and benefits acquisition. In many cases, improvement in daily living skills will help the client attain a higher level of functioning. Services must be delivered consistently over a lengthy span of time since many individuals in this target population exhibit chronic substance abuse problems. Finally, service providers should recognize that full recovery may never occur; improvement in the level of functioning, in health status, and in the number of days intoxicated are more realistic goals for many of these clients than is a lifetime of sobriety. Contains nine references. (RJM)

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Comprehensive Substance Abuse Services for Homeless Persons with Alcohol and Other Drug Problems

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I. Introduction and Background

The purpose of this presentation is to discuss the optimal design of comprehensive treatment services for the target population of homeless persons with alcohol and other drug problems. Traditional substance abuse services generally have not been responsive to the needs of this target population. However, beginning six years ago, stimulated by initiatives from the Homeless Demonstration and Evaluation Branch of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), a number of innovative interventions have been introduced and evaluated. While we will not be explicitly describing these programs today, these efforts have been seminal in shaping our own work and this presentation. (See Kirby and Braucht, 1993, for a description of the intensive case management program that was supported by the NIAAA Homeless Demonstration and Evaluation Branch in Denver.)

II. Comprehensive Substance Abuse Treatment

A. Institute of Medicine Report.

To provide context for this discussion, an overview of the treatment modalities and settings that presently comprise the typical continuum of substance abuse services is requisite. From our perspective, the most coherent approach has been set forth by the Institute of Medicine

(IOM) in its seminal report, "Broadening the Base of Treatment for Alcohol Problems," published in 1990.

In an effort to refine the definition of treatment, the IOM report makes an important distinction between: (1) stages of treatment; (2) the settings in which these stages can occur; and (3) modalities.

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Stages: Three stages were identified: (1) Acute intervention, which encompasses emergency treatment, detoxification, and screening. (2) Rehabilitation, which includes evaluation and assessment, primary care, and extended care (stabilization). (3) Maintenance, comprising aftercare, relapse prevention and domiciliary care.

Treatment Settings: Treatment settings were conceptualized as falling into four categories: (1) Inpatient---a hospital or other licensed medical facility for patients who require 24-hour supervision. (2) Residential---also 24-hour supervision, but in a non-medical or less intensively medical facility. (3) Intermediate---sometimes referred to as partial care, which is appropriate for individuals who require less than 24-hour care but who need more intensive care and support than is available in an outpatient setting. (4) Outpatient---defined as nonresidential services on both a scheduled or nonscheduled basis.

Treatment Modalities: The IOM report also defines treatment modalities as separate from both the treatment stage and the setting, denoting modalities as the activities that are

deployed to relieve symptoms or to change behavior. The many activities that have been utilized are conceptualized by three broad categories: (1) pharmacological; (2) psychological; or (3) behavioral.

It is important to note the following statement of the IOM committee: "The committee considers it possible to carry out any of the stages of treatment for alcohol problems in any of the settings, should the individual's clinical status merit that placement." (1990, p. 72) Similarly, modalities may be relevant to any stage or setting, depending on the individual needs of each person.

III. Services for Homeless Persons

A. Scope of the Problem.

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Homeless persons with alcohol and other drug problems represent a sizeable percentage of the total homeless population. In fact, recent estimates have estimated that, at a minimum, approximately one third of all homeless persons have an alcohol problem (Fisher and Breakey, 1987; Koegel and Burnham, 1987). In addition, another 10% to 25% have drug problems (Millburn, 1989; HUD, 1989). As a general rule, the more credible the research, the higher the rate of substance abuse revealed.

Not only is substance abuse a pervasive problem among the homeless, but there is an

abundance of evidence to support the conclusion that homeless persons who are affected by alcohol and other drug abuse experience multiple other problems as well. They suffer from more numerous and severe health problems, vocational disabilities, and tend to display a higher rate of concomitant mental illness. Further, this population tends to be older, male, and to have longer durations of homelessness (Fisher, 1990), is more prone to housing instability (Drake, Wallach, & Hoffman, 1989, Drake et al, 1991), more likely to have been incarcerated, more prone to personal victimization, and less likely to have contact with family members or other people (Blankertz, Cnann, White, Fox & Messinger, 1990; Koegel & Burnham, 1987).

B. Accessibility to Substance Abuse Treatment Services.

Homeless people typically encounter serious problems accessing substance abuse treatment programs. Some of the more significant of these problems are:

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- Because they lack stable housing, if they are to access the traditional treatment continuum described earlier, typically services are delivered in either an inpatient or residential setting. However, inpatient and residential settings are prohibitively expensive, and there is a limited number of slots available. Moreover, the variation by state and locality in available slots is sizeable; some rural areas have no residential beds, and programs concentrated in urban areas are often characterized by extensive waiting lists.

- On the other hand, because they have transportation and other problems that interfere with the intensity and continuity that is essential for long-term outpatient treatment, traditional outpatient treatment is inappropriate for most homeless persons. To compound this problem, those programs that are located in sites that are accessible to homeless people all too frequently are the ones with the longest waiting lists.

- As reviewed earlier, because homeless persons present for treatment with a multiplicity of problems in addition to or associated with their substance abuse, treatment providers frequently refuse to enroll them into treatment. For instance, many non-medical residential programs explicitly exclude people with certain types and severity of medical problems.

- Homeless people are often distrustful of and resistant to the more bureaucratic features of treatment programs. They will not comply with the requisite paperwork and other requirements for admission.

- Traditional substance abuse treatment programs have not been marketed to homeless populations. Thus, even when there are available slots, because the services delivery systems that work with homeless persons are so fragmented, awareness about available slots may be non-existent.

The multiple problems that characterize this population must be addressed either prior to or

concomitantly with the substance abuse treatment. An exclusive focus on the alcohol or other drug problem is insufficient for at least two reasons: (1) first, unless the material and medical needs of the client are met, efforts to increase the client's ability to function through treatment will have a very low probability of success; and (2) second, homeless individuals with alcohol and other drug problems perceive their other problems as more important and tend not to evidence sufficient motivation for treatment until these more immediate and pressing needs are addressed.

Finally, the goals of treatment for this population need to be briefly discussed. A sizeable percentage of the target population of homeless people with alcohol and other drug problems evidence chronicity in terms of their substance abuse problems. Indeed, there is considerable overlap in the chronic public inebriate population and the target population. The mission for most traditional substance abuse treatment programs is to provide the client with the foundation for a lifetime of sobriety and productivity. This goal, of which abstinence is the centerpiece, may not be reasonable and attainable for persons who exhibit chronic abuse histories. For the chronic public inebriate, a reduction in the number of days intoxicated following treatment and improvement in health may be a more realistic objective than a lifetime of sobriety.

In broad terms, the most appropriate and relevant goals for the chronic public inebriate are to: (1) afford the client a period of residential stability in which the multiple acute problems can be addressed; (2) link the client to services that address those problems that are outside the realm of substance abuse treatment; and (3) assist the client to improve his or her level of functioning.

With these goals in mind, the typical requirement of sobriety in treatment must be applied with flexibility. Relapse is common with this population. It is completely inappropriate, from our perspective, to apply a blanket policy that dictates the discharge of a homeless person from a residential setting, in effect throwing him or her back onto the streets without adequate supports, because of a relapse.

IV. Comprehensive Substance Abuse Services for Homeless Persons

Having identified the more salient problems facing homeless people who are in need of substance abuse treatment services, now we turn to the principles that guide the design of more effective substance abuse treatment services.

A. Residential Treatment/Housing.

Because housing is central to the needs of this target population, it merits special attention in this presentation. By definition, homeless people lack a stable, safe place of consistent residence. Accordingly, the most appropriate setting within the traditional continuum of substance abuse services is a residential treatment program. In addition, in programs that have modified this setting to accommodate the high prevalence of chronic substance abuse in this population, the length-of-stay in this residential setting may be substantially longer than is the case with the standard 28-day program. For example, Shandler and Shipley describe such a program in Philadelphia, in which the duration of residential treatment is approximately four months (1987, 54-56.)

While residential treatment certainly addresses the homeless problem, at least for that period in which the client is enrolled, once the client has been sufficiently stabilized, alcohol- and drug-free housing may offer a viable alternative to residential treatment. Three consideration are paramount here. First, residential treatment is relatively expensive, and, in a era of managed care, providers must allocate residential beds to those individuals most in need of that level of intensity. Utilizing residential beds for housing will become increasingly difficult to justify. Second, there are ethical issues in denying services to numerous other prospective clients in order to provide several months of residential treatment to one homeless client, even though the needs of that individual may indicate the appropriateness of long-term treatment in this setting. Third, this population must eventually return to community living. Residential treatment, especially for an extended period of time, removes the individual from the exigencies of daily living, rather than preparing them for community survival. An effective housing program, combined with case management or some similar strategy, can offer the benefits of a community-based residence, intensive treatment, case management, and it is less disruptive to the transition back into community living than treatment in a residential setting.

A number of programs around the country have demonstrated success in placing chronically debilitated and homeless clients in housing, with an intensive case management program that can secure for these clients the substance abuse and other services that they require. Sometimes housing is "wet" or "damp," permitting residents to use alcohol on the premises or to enter the premises while under the effects of use; in other cases, housing is alcohol- and drug-free as a fundamental requirement of residency.

We have a fulltime housing coordinator at Arapahoe House and are in the process of developing a range of housing options. We have found that outpatient treatment can be very effective with this population, when it is provided in concert with placement in stable housing, and a program which ensures that the other services which the client needs access to---medical, mental health, vocational, and financial assistance---are also made available.

In the absence of stable, affordable housing and an intensive case management program, it is considerably more difficult to meet the multiple needs of this target population, and one may have few options other than residential treatment. Certainly, without case management or some similar strategy, outpatient treatment is generally not indicated for this population.

B. Continuum of Treatment Services.

While homeless people with alcohol and other drug problems may be characterized accurately as displaying a unique constellation of needs, they also share some salient characteristics with other people with alcohol and drug problems. Thus, many of the following principles, while germane to the needs of homeless individuals, are generically applicable to the larger population of people affected by alcohol and other drug problems.

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- Residential stability is essential. In the absence of a safe and, preferably, alcohol- and drug-free setting, in which the individual can reside, treatment cannot

be effective.

- When the individual is sufficiently motivated or engaged to seek treatment, it is imperative that treatment be available immediately; timing is everything with a substance abuse problem.

- Engagement of the client is essential to the commitment that must be made if recovery is to be achieved. Special strategies are often required to engage homeless people. Assistance with housing is effective in attracting many homeless people; a requirement that substance abuse treatment be satisfactorily completed prior to attending to the client's other needs represents an unnecessary barrier for many homeless people.

- Assessment is a requisite first step which determines (1) the nature of the client's substance abuse problems, (2) his or her personal characteristics that may be relevant to treatment, (3) the level of initial placement in the continuum and development of a preliminary treatment plan, and (4) the other areas of need which must be addressed, such as health care or mental health treatment.

- A physical exam and history are conducted to identify medical and dental problems and to include the appropriate medical and/or pharmacological activities in the treatment plan.

- HIV/TB and other infectious disease counseling should be incorporated, where

appropriate.

- Continuity of care, as well as coordination of care, is vital to improve the odds of recovery. Chronic substance abuse, which characterizes much of the homeless population with alcohol and other drug problems, requires long-term care. Relapse is not an uncommon occurrence with this population, and it has different implications that it might have with a more middle class population. Services must continue, even in the face of multiple relapses; services should not be contingent on sobriety.

- Treatment must be individually tailored to the needs, strengths, and circumstances of each person. The old adage, "An alcoholic is an alcoholic is an alcoholic. . ." may contain a kernel of wisdom, but should not be interpreted to indicate that clients and their substance abuse problems are homogeneous. The degree of heterogeneity among clients is striking and demands that the treatment regimen for each one is individualized to be maximally effective.

- Intensive case management is a potentially powerful strategy for assuring continuity of services horizontally (i.e. over a significant span of time) and vertically (i.e. across the various systems and agencies) to meet the individual needs of each client, irrespective of where the appropriate services to meet these needs may be located. In our work, the key to improvement in functioning for these clients has been the amount and kind of services delivered. Case management is not essential in this equation, but it does offer a coherent approach that explicitly addresses the multiple needs of the client and assigns responsibility for coordination of services

delivery to one individual or team. The basic functions of case management that are instrumental to the successful delivery of comprehensive treatment services to this population must be fulfilled by someone who is assigned responsibility for them. It is not sufficient to make referrals; clients must be successfully linked to the services they need.

V. Conclusions and Summary

Homeless people with alcohol and other drug problems present the traditional substance abuse services delivery provider with a sub-population that requires the development of specialized services that are designed to meet their unique constellation of needs. First, because they are homeless, at the point of initial contact, engagement and immediate access to a safe setting in which to at least temporarily reside must have priority over other services. Second, as with all people who are affected by alcohol and other drug problems, this target population requires placement in the appropriate level of care in a continuum of substance abuse services. Third, through intensive case management or some alternative strategy, the multiple other needs of these individuals must be effectively addressed, including health and dental care, mental health treatment, vocational training, benefits acquisition. In many cases, improvement in daily living skills is required for the client to attain a higher level of functioning. Fourth, services must be delivered consistently over a lengthy span of time; many of the individuals in this target population are characterized by chronicity in their substance abuse and other problems, and therefore services must be appropriately structured over time to address this chronicity. Finally, we must be cognizant that full recovery may never occur; improvement in level of functioning, in health status, in

the number of days intoxicated, are more realistic goals for many of these clients than is a lifetime of sobriety.

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TREATMENT STAGES

Most Commonly Used:

- Detoxification
- Rehabilitation
- Aftercare

IOM Revision

Stage 1: Acute Intervention

- Emergency Treatment
- Detoxification
- Screening

Stage 2: Rehabilitation

- Evaluation and assessment
- Primary care
- Extended care (stabilization)

State 3: Maintenance

- Aftercare
- Relapse Prevention
- Domiciliary care

TREATMENT SETTINGS

- Inpatient
- Residential
- Intermediate
- Outpatient

TREATMENT MODALITIES/PROCEDURES

- Drugs to manage intoxication
- Drugs used to manage withdrawal
- Drugs used during rehabilitation
- Drugs used to attenuate drinking behavior

Slide 1

HOMELESSNESS AND SUBSTANCE ABUSE

SCOPE OF THE PROBLEM

Prevalence

- Approximately one-third of all homeless persons have an alcohol problem
- In addition, another 10% to 25% have drug problems

Multiple Other Problems

Homeless persons with alcohol and other drug problems:

- Suffer from numerous health problems, may have severe disabling conditions
- Are characterized by chronic joblessness and vocational deficits
- Evidence higher rates of concomitant mental illness
- Tend to be older, male and have longer duration of homelessness
- Are more prone to housing instability
- Are more likely to have been incarcerated
- Are more prone to personal victimization
- Are less likely to have sustained contact with family members

Slide 2

PROBLEMS WITH ACCESSIBILITY TO SUBSTANCE TREATMENT SERVICES

- Need residential treatment, which is scarce and expensive
- Outpatient treatment is not viable, in absence of housing and case management
- Multiplicity of other problems excludes from enrollment in many treatment programs
- Target population tends to be distrustful of bureaucratic features of treatment programs
- Traditional treatment programs have not marketed to the homeless

Slide 3

CONTINUUM OF SUBSTANCE ABUSE TREATMENT SERVICES

- Residential stability
- Immediate treatment availability
- Engagement
- Assessment --- treatment plan and level of placement
- Physical exam and history
- HIV/TB and other infectious disease testing and counseling
- Continuity of care and coordination of care
- Treatment tailored to individual needs
- Intensive care management to ensure linkage to services matching the needs of each client, vertically and horizontally

Slide 4